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Approaches to Mental Illness in Madagascar: A Case for Reconciling Reason with Faith

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Approaches to Mental Illness in Madagascar:

A Case for Reconciling Reason with Faith

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Abstract

This paper expounds the shortcomings of the mental health provisions inherent in the current primary health care system in Madagascar in light of its limited accessibility to the Malagasy. Integrating traditional medicine with allopathic psychiatric care is proposed, with attention to prevailing Malagasy beliefs in spiritual possession as the basis for mental illness, in order to accommodate the discrepant worldviews espoused by physicians and their Malagasy patients that inhibit the efficacy of public mental health care. Through an integrated system based on the model piloted at the Clinique de Manongarivo in northwestern Madagascar, the financial, physical, and epistemological barriers that presently stunt the reach of the public mental health services would be dissolved in order to promote sustainability in the domains of economy and biodiversity.

Introduction

According to the study, “Les troubles psychiatriques à Madagascar: étude clinique de 376 cas répertoriés à Mahajanga,” mental disorder-linked causes account for approximately 12% of global morbidity in under-developed nations among adults between 15 and 44 years old (Andriantseho et al., 2004, p. 122). The World Health Organization (WHO) contends that Madagascar’s allopathic healthcare system hardly summons an attempt to support the mental health needs of its people, with 0.05 psychiatrists per 100,000 Malagasy, compared to the United States’ national average of 11.4 psychiatrists per 100,000 Americans (World Health Organization, 2011; The Dartmouth Atlas of Healthcare, 2013). The quality and quantity of mental health services in the United States have deservedly received considerable scrutiny, especially since the state budget cuts related to the 2009 economic recession, from both academia and public news sources for under-serving and overcharging target populations (Kliff, 2012). On the other hand, the conspicuous lack of literature relating to Madagascar’s respective mental health services indicates that the nation’s priorities have been and still are concentrated elsewhere.

The Economy of Primary Mental Health Provisions in Madagascar

Primary health services in Madagascar subsume the treatment of “severe mental disorders,” and, according to the WHO, “the majority of primary health care doctors have received official in-service training on mental health within the last five years” (World Health Organization, 2011). In 2005, carbamazepine, phenobarbital, sodium valproate, chlorpromazine, diazepam, and haloperidol,

whose therapeutic applications are summarized in Table 1, comprised the selection of psychoactive medications most widely distributed and available among facilities in Madagascar offering primary health care services (World Health Organization, 2005). Accordingly, while

individuals are consulted by mental health practitioners free-of-charge in public facilities, the burden of paying for psychotropic drug prescriptions rest with the patient and his or her family.

This dependence on a certain level of financial clout

to obtain the necessary pharmaceutical treatment for a mental disease

unfortunately establishes socioeconomic status as a key determinant of accessibility

to mental health services. In this vein, a 2007 estimate projects that two-thirds of

the Malagasy population survive on less than US\$2 a day, indicating a dearth of

financial means among families in Madagascar to pay for medical products (A.

Rasamindrakotroka, personal communication, June 27, 2013). Similarly, even if a

family is endowed with the funds to cover essential medical expenses, which tend to

range from 5,000-10,000 Ar per hospital visit, it seems unlikely that drugs fostering

mental wellness would be considered significant compared to those used as malaria

Drug	Drug Class	Therapeutic Applications
<i>Carbamazepine</i>	Anticonvulsant; mood-stabilizer	Epilepsy; bipolar disorder
<i>Phenobarbital</i>	Barbiturate; anticonvulsant	Epilepsy
<i>Sodium valproate</i>	Anticonvulsant	Epilepsy; anxiety disorders; bipolar disorder
<i>Chlorpromazine</i>	Antipsychotic	Schizophrenia
<i>Diazepam</i>	Benzodiazepine	Epilepsy; anxiety disorders; insomnia; alcohol withdrawal
<i>Haloperidol</i>	Antipsychotic	Schizophrenia

Table 1: Most common psychotropic medications available at primary health facilities in Madagascar (World Health Organization, 2005)

prophylaxis or to cure diseases more imminently threatening than mental illness (Rakotondrasana, personal communication, July 5, 2013).

Mental Health Is Not a National Priority

The consistency and quality of health care within the Malagasy health care system depend intimately on federal monetary and administrative support. Furthermore, the implementation of mental health services at primary health facilities requires that mental wellness be prioritized as a fundamental characteristic of a healthy population. Evidence indicates that this philosophy has not yet been adopted by Madagascar's Ministry of Health, or at least that the means for its promotion have not yet been acquired. Marc Ravalomana's presidential reign from 2002-2009 was marked by the initiation of several reforms targeting poverty in Madagascar and its manifestations, including those directly related to Malagasy health. In 2003, Madagascar adopted the WHO's Third Millennium Development Goals 4-6 that targeted "reducing child mortality, improving maternal health, and combating HIV/AIDS and other diseases" (A. Rasamindrakotroka, personal communication, June 27, 2013). Under Ravalomana's two successive presidential administrations, the Poverty Reduction Strategy Papers and the Madagascar Action Plan defined the specific development objectives of the nation, emphasizing preventative measures such as promoting personal hygiene, proper nutrition, family planning, and an improved national infrastructure to augment the quality of life available to Malagasy (A. Rasamindrakotroka, personal communication, June 27, 2013). In this way, while the focus within Madagascar's public health sector has been drawn to the most basic elements that underlie healthy and sustainable human

functioning, it has become clear that mental health does not make the list of chief concerns. While mental health of a population does correlate to an extent with the satisfaction of its primary needs, efforts to improve access to clean water, healthy food, and a hygienic lifestyle, for example, do not account for those who are chronically impaired with respect to cognition, victims of emotional trauma, or suffering from mental diseases with biological bases.

Given the deterioration of Madagascar's politically affiliated institutions since the "coup d'état" of 2009, it is highly idealistic to expect that psychological support at the federal level for Madagascar's population be prioritized and expanded to meet the statistical need in the near, foreseeable future. If the mental health provisions of the nation are to be improved in terms of accessibility, any proposal for feasible reform must fit within the framework of health provisions presently available, and it must not be more costly for both the government and patients alike than the current system. In this way, traditional medicine, which already accounts for approximately 80% of the therapeutic attention received by Madagascar's overwhelmingly rural population, remains the most plausible and accessible option for occupying the void where Madagascar's public mental health services are conspicuously absent and moreover insufficient (Farnsworth, 1988).

Methods

All information collected throughout the research process and employed in this paper derives from primary sources, individual interviews, and independent literature studies. Lectures held at the University of Antananarivo and in Andasibe,

Madagascar supplied many facts relating to the historical context or background details of my topic, and specific questions asked directly to lecturers elicited responses serving my interests in Madagascar's mental health services. Excursions to the respective homes or worksites of individuals working locally in the health sector, such as Andasibe's Centre de Santé de Base (CSB) II, also provided opportunities for discussions with those possessing first-hand knowledge regarding traditional and/or allopathic health care in Madagascar. Written notes were employed to record the main points of each lecture or discussion, and the PowerPoint files for several lectures were referenced to preserve the accuracy of information in this study.

It must be noted that language barriers often existed between primary sources and SIT students. Accordingly, Dr. Nat Quansah often served as the liaison between parties by providing necessary translations for questions asked and responded to from English to French or Malagasy and vice versa. In this way, it is possible that certain nuances of testimonies failed to or could not be communicated through translational procedures and, resultantly, were not included among my interpretations.

Finally, independent research was conducted by way of collecting journal articles, news reports, and statistics from online databases and encyclopedias. Unfortunately, the body of literature available regarding the state of mental health services in Madagascar is not complete or regularly updated, and there remains likewise a deficiency of sources providing insight into Malagasy traditional medicine's approach to treating psychological ailments.

Research Findings

Culture and Conceptualizations of Mental Disease

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM) serves as the reference for conceptualizations of mental disease per the Western, allopathic tradition. This anthology of mental disorders and their telling symptoms thus defines the line between “normal” and “psychologically afflicted” along the spectrum of cognitive functioning. Chapter 2 of Mental Health: A Report of the Surgeon General asserts, “Mental disorders are characterized by abnormalities in cognition, emotion or mood, or the highest integrative aspects of behavior...” (The United States Department of Health and Human Services, 1999, p. 39). While the term “abnormality” is vague and its application to mental disease likely inconsistent cross-culturally, the DSM functions to standardize the definition of the psychological norm in all of its manifestations so that allopathic medicine can be taught and practiced in the same manner across the globe. “Modern,” or Western, science upholds that “our subjective mental lives reflect the overall workings of the brain,” and furthermore deviations from conventional balances of neurotransmitters and the corresponding cellular receptors are used to explain the biochemical bases of many mental diseases (The United States Department of Health and Human Services, 1999, p. 39). Pharmaceutical companies design products that supposedly work to return the brain to its normal state by targeting underperforming dendrite receptors or increasing the amount of a particular molecule present in the neuronal synapse. For example, the first-generation antipsychotic drug, chlorpromazine, antagonizes D₂ dopamine receptors to account for the excess dopamine stimulation

that characterizes schizophrenia (M. Upchurch, personal communication, February 5, 2013). Accordingly, allopathic psychiatrists or other mental health professionals licensed to prescribe medication are expected to stay up-to-date on new editions of the DSM so that their understandings of mental disease and the function of drugs designed to alleviate related symptoms can evolve alongside the expanding body of scientific research.

When considering the potential for traditional medicine to fill the gap between the current mental health provisions in Madagascar's public health sector and the neglected demand for such services, one must note the discrepant conceptualizations of mental disease in allopathic versus traditional Malagasy thought systems. The allopathic tradition and approach to medical practice may be considered an extension of Western culture, with its basis in empiricism and rationalizing therapies through systematic trial and error to produce a quantifiable measure of a drug's efficacy. Conversely, Malagasy traditional medicine is founded on a distinct set of beliefs belonging to an ancient tradition of ancestral worship and intimate reliance on local flora, among other motifs. According to the United States Department of Health and Human Services, "Cultural identity imparts distinct patterns of beliefs and practices that have implications for the willingness to seek, and the ability to respond to mental health services" (The United States Department of Health and Human Services, 1999, p. 82). It is possible that the scope of Malagasy worldviews, many of which are spiritually founded, may influence the accessibility of the public allopathic mental health system in Madagascar as potently as physical and financial barriers. Hence, in order to understand the role of traditional medicine

in a possible future mental health system and how it may be received by Madagascar's population, the prevailing religious views of the Malagasy must be expounded.

Malagasy Religious Traditions

Among the Malagasy, traditional medicine's credibility as a valid means of psychiatric therapy rests on its compatibility with the preconceptions of possible adherents. According to the CIA World Fact book, 52% of the Malagasy people embrace traditional beliefs. Many of these views center on the living's connection to their deceased ancestors and are exemplified in the various practices upheld by traditional healers. The remaining 48% of the nation's constituents are spiritually divided as Roman Catholics, Protestants, and Muslims, although these religious associations do not exclude the possibility that many Christians or Muslims uphold certain inherently Malagasy beliefs and practices (Central Intelligence Agency, 2013).

Fundamental parallels that render the traditions complementary can rationalize the fluid integration of distinctly Malagasy and Abrahamic spiritual customs among many populations. Malagasy beliefs that predate the nation's colonial era are monotheistic, and thus in order to appeal to Madagascar's populations, "Christian missionaries were able to build on the Malagasy concept of a supreme God by using the term, 'Andriamanitra,' to refer to the biblical God and by choosing one of the traditional terms for the soul, *fanahy*, to define its Christian counterpart" (SPDH Reader, 2004, p. 5). In the same vein, "Christian belief in the power of a transcendent and somewhat distant God has blended with older beliefs

in the closeness and intimacy of the dead as spiritual beings” (SPDH Reader, 2004, p. 5). Accordingly, while Malagasy Catholics, Protestants, and Muslims preserve their religion’s respective means of paying homage to a single omniscient creator, the shared vision of divine beings as superior to mortals trapped in their Earthly lifecycle leaves room for also adopting the ancestral veneration characteristic of Malagasy customs. In summary, a certain level of homogeneity among the religious convictions of the Malagasy, including the nearly universalized emphasis on the spiritual ascendancy achieved through death, unites Madagascar’s myriad of ethnic traditions.

Spirituality’s Role in Malagasy Traditional Medicine

The traditional healers that our group consulted at Doany Kingory, an area considered sacred for its cultural relevance as an ancient burial site, attested to the survival of spiritual practices employed for their healing properties (Desire et al., personal communication, June 24, 2013). At Doany Kingory, we witnessed the healers experience *tromba*, the spiritual possession of an individual by ancestral forces. In his lecture, “Traditional Medicine of the Merina,” Dr. Solo Raharinjanahary described how *tromba* and *adorcismes*, the process of communicating with spirits invited to a specific room; elucidate the herbal prescriptions necessary to treat a patient’s symptoms (S. Rahavinjanahary, personal communication, June 17, 2013). Additionally, exorcisms (*bilo*), divination based on the pattern of thrown seeds (*sikily*), and astrological predictions (*fanandroana*) represent the scope of spiritual tactics employed to ward off bad spirits or infer the proper course of treatment for a particular malady (S. Rahavinjanahary, personal communication, June 17, 2013).

Just as one's reliance on clinically tested allopathic medicines implies trust in empiricism and scientific induction, each of these spiritual medicinal approaches transcends the realm of the tangible and thereby only appeals to patients with corresponding existential beliefs, one clear limitation of the general applicability of traditional medicine.

Malagasy Conceptualizations of Mental Disease

As aforementioned, despite the varying religious denominations to which the Malagasy belong, the majority of Madagascar's people believe they are "susceptible to spiritual possession" and that even those who are not Malagasy share the same potential (L. M. Lyon, L. H. Hardesty, 2005, p. 293). To support this notion, the Programme National de Santé Mentale states that within Malagasy belief systems, "Le plus souvent reconnues comme des maladies de l'esprit ou maladies surnaturelles, [les maladies mentales] s'opposent aux maladies reconnues comme naturelles. Leur étiologie est attribuée le plus souvent à des actes de sorcellerie, à des possessions par des esprits mal intentionnés, au non respect des devoirs dus aux ancêtres, à la transgression de tabous...par exemple" (J. L. Robinson, 2007, p. 12). In this way, suspicions regarding the violation of taboos (*fady*) and the subsequent supernatural consequences permeate nearly every Malagasy demographic, a fact that simplifies conclusions rendered regarding the conceptualization of mental disorders in Madagascar.

Traditional medicine's approach towards the alleviation of mental illness is symptomatic: healers depend entirely on observations of and personal testimonies from the patient or their family members to determine if a psychological agitation

indeed exists. Unlike with certain physical maladies, such as a toothache or menstrual cramps, that are associated with localized, tangible, and typically standard characteristics, mental disorders are ambiguous and often difficult to isolate from circumstantial social/environmental elements. However, Malagasy traditional medicine avoids the allopathic complication of having to address each psychological symptom separately and assign it to a specific disorder. The traditional healers at Doany Kingory explained that individuals perceived to be mentally ill have been possessed by evil *tromba*, bad spirits who seek retribution for the violation of specific *fady* (Desire et al., personal communication, June 24, 2013). Rather than treating the behaviors, like psychosis or violent bouts of anger, healers must divine the means of exorcising the *tromba* or clearing individuals of their spiritual inhabitants. Some healers, including those at Doany Kingory and of the Antanosy people in southeastern Madagascar, succeed at eliminating *tromba* through a combination of specific plant-based remedies and traditional rituals (L. M. Lyon, L. H. Hardesty, 2005, pp. 287-294). Unfortunately, the lack of readily accessible literature enumerating the plants harvested in Madagascar for the treatment of mental illnesses prevents the elucidation of specific traditional remedies.

Limits of Allopathic Mental Health Services in Madagascar

When herbal remedies distributed and exorcisms performed by traditional healers to rid individuals of psychological demons fail to successfully relieve the mentally agitated of their symptoms, healers or patients' families might refer the afflicted to the nearest CSB or higher level public medical institution. However, in

addition to the aforementioned financial barriers to fully capitalizing on the primary public health services in Madagascar for a large faction of the Malagasy, several factors remain impediments to the success of the current allopathic system in the domain of mental health.

A NEED THAT CANNOT BE MET

A 2000 estimate promulgated by le Programme National de Santé Mentale indicates that 47% of Malagasy suffer from some brand of mental affliction, as measured by the Mini International Neuropsychiatric Interview (MINI) (J. L. Robinson, 2007, p. 17). General anxiety (affects 29% of the population), depression (18.5 %), and alcoholism and its accompanying psychological effects (8.5%) represent the most prevalent illnesses detected by the MINI, however, the study acknowledged that the political strife in 2000 during the term of President Didier Ratsiraka may have amplified the psychological stress experienced in Madagascar (J. L. Robinson, 2007, p. 17; A. Rasamindrakotroka, personal communication, June 27, 2013). More recent statistics summarizing the mental health status of Madagascar do not seem to exist, or at least could not be found, but with the current political instability and civilian unrest since the deposition of President Marc Ravalomana in 2009, it seems likely that a comparable need for mental health services persists.

Given that approximately 70% of the population qualifies as “rural,” one can assume that the majority either have access to CSB Is, the most basic of primary health clinics and staffed solely by a paramedic, or reside in remote locales lacking any semblance of public health services (CIA World Fact book, 2010). Currently, Madagascar has a single institution or “asylum” dedicated to treating the mentally

ill: l'Hôpital Psychiatrique de Anjanamasina in Antananarivo. With 120 beds and around 60 physicians and nurses, Anjanamasina provides services for the severely impaired or incapacitated, but the allotments certainly do not suffice for treating the chronic mental ailments experienced within Antananarivo's city limits, and much less for a population of 22.5 million (CIA World Fact book, 2010). In short, the most significant limit of allopathic mental health services in Madagascar is the dearth of licensed practitioners and funded clinics in which they can function. Before a family can decide whether or not they have the means to purchase chlorpromazine or haloperidol for their ailing loved one, a doctor or nurse must first consult the psychologically afflicted to determine whether her or she even requires some form of therapy. Thus, physical access to mental health services is the primary determinant of an individual's potential for treatment.

DISCREPANT BELIEF SYSTEMS

Interestingly, it seems that the efficacy of psychiatric attention is highly contingent upon the patient's understanding of his or her own illness. To this effect, in "Traditional Healing in the Contemporary Life of the Antanosy People of Madagascar," L. M. Lyon and L. H. Hardesty state, "Psychiatrists tend to fail the possessed because they view possession as deviant behavior rather than illness" (L. M. Lyon and L. H. Hardesty, 2005, p. 292). If the majority of Malagasy believe in spiritual possession, it seems likely that many will justify seemingly abnormal behavior with the presence of a malevolent spirit. However, if these individuals are dismissed by their psychiatrists as frauds or "deviants" wishing to defend malfeasant actions with supernatural causes, the proper treatment, whether or not

allopathic, will certainly not be administered.

L. A. Sharp reached a similar conclusion while studying treatments for the possessed among the Sakalava people of northern Madagascar. The author writes, “Biomedicine as applied in northern Madagascar is a system that is exclusionary of other belief systems: specifically, psychiatric training requires a reordering of beliefs that make it impossible for psychiatrists to comprehend their patients, *even if they share a similar cultural background*” (L. A. Sharp, 1994, p. 526). Psychiatrists are shaped to confront mental illness as a series of imbalances in the brain combined with behavioral and social factors, but when the plight of patients presented with a spiritual affliction is reconstructed to fit the allopathic model, physicians forfeit the ability to fully connect with their clients and understand an illness from the patient’s perspective. Consequently, discrepant worldviews between empirical medical practitioners and patients with deeply engrained spiritual beliefs pose a threat to the successful diagnosis and treatment of mental disease via allopathic methods. This in turn discourages communities that uphold traditional Malagasy spiritual views with a particular zeal to use allopathic mental health provisions. According to C. M. Aghukwa, the mental health-seeking behavior of a population, and furthermore the “choice of mental health healers,” is guided by its conceptualizations of mental disease (C. M. Aghukwa, 2012). Hence, when the practice of mental health professionals does not accommodate the beliefs regarding the bases of mental illness endorsed by the population for which the services are being provided, a tension that likely exists in Madagascar, families will turn to traditional healers for mental health support.

Integrated Health: A Possible Avenue for Resolution

Considering the insufficiency of the modern primary mental health provisions in Madagascar limiting their accessibility to the population financially, physically, and epistemologically, integration of allopathic and traditional services poses the most promising avenue for expanding the scope of its benefits to the Malagasy. By harnessing the advantages of both medical systems, a complementary structure would likewise diminish the drawbacks associated with Madagascar's mental health system.

To fill the mental health gap, the development of collaborative physician-traditional healer professional relationships similar to that piloted in the Clinique de Manongarivo by Dr. Nat Quansah is proposed. Dr. Quansah's Integrated Health Care System (IHCS) "acknowledges, appreciates, respects and embraces cultural, biological, economic and technological diversities as well as the diversity of human capabilities and harnesses these to function in a complementary manner to meet its goal of HEALTH FOR ALL and HEALTH OF ALL" (N. Quansah, personal communication, July 1, 2013). Both an allopathic physician and a traditional healer, who employed their respective skills to diagnose a patient's physical malady and then discussed their conclusions, presided over health consultations at the clinic. When the parties agreed, they decided together on the appropriate course of treatment, giving priority to traditional remedies that made use of the local biodiversity and were inherently much more cost-effective than a pharmaceutical product. However, in the case that the traditional healer was unaware of an effective therapy, the physician would then prescribe a medication for the ailment. The

project was designed to be sustained infinitely by the community through the establishment of a mutual insurance fund that would require all participants to pay a small yearly fee that would cover all overhead expenses, as well as the cost of medications prescribed.

Such a system could apply to the mental health needs of the Malagasy if the traditional healer served as a liaison for community members that conceptualize mental diseases as a manifestation of spiritual disturbances. In the instance that a patient appeared an imminent danger to themselves or others, the healer and physician could work together to execute both the appropriate spiritual rituals and prescription of the pharmaceutical products that function to eliminate the symptoms in question. A benefit of this collaboration would be increased confidence among the population being served in public mental health care, as the healer would be appointed from within the community and would thus already possess the trust of its people. More importantly, though, the mental health services would accommodate the spiritual backgrounds of clients by offering therapy for both the mind and soul. If such an integrated system were to materialize, holistic mental health care would be accessible to a greater spread of individuals in Madagascar for it would be more tolerable to both their pocketbooks and epistemological convictions. Similarly, although a wide installation of such clinics would require support from administrative bodies at the outset, the eventual self-sustenance of the integrated clinics, as provided by the community support funds, would render them essentially independent of financial support from Madagascar's government.

Conclusion

As with many of the deficiencies identified within the social support network for the people of Madagascar, governmental disorganization, corruption, and insubstantial funding within both the public and private sectors bear much of the responsibility for the neglect observed in public, subsidized attention to mental wellness. It seems that geographical demographics signify the most potent determinant of who will receive allopathic mental health attention when the need arises. For example, there are few, if any, primary health clinics on the island that offer more than referrals to l'Hôpital Psychiatrique de Anjanamasina for severe cases, such as paranoid schizophrenia or borderline personality disorder. Accordingly, individuals seeking relief for mental afflictions may have no other option than to look to their local traditional healers for aid. On the other hand, traditional healers may be the preferred consultants for therapy among those who prioritize spiritual beliefs that isolate them from adequate allopathic psychiatric provisions. However, through an integrated health system similar to that developed at the Clinique de Manongarivo by Dr. Quansah, it would be possible for the tension between receiving spiritual and biological care to be mitigated. While the allopathic system boasts the use of a wide range of pharmaceuticals to treat mental disorders for which plant remedies in Malagasy traditional medicine may not exist or may not be harvested throughout every region, psychiatrists and general physicians trained in mental health practices are not conditioned to be receptive to claims of spiritual possession or influence as valid bases for mental illness. The integrated health system, while promoting sustainability of both the economy and biodiversity of

Madagascar, would eliminate concerns of accessibility of mental health services within the current framework by maximizing the value of health practitioners and resources already contained within the country. The government could use the funds it currently expends on subsidizing psychotropic medications and paying the overhead costs for health clinics to erect new integrated clinics in regions suffering from neglected health needs, and, with the installation and enforcement of mutual funds, it could eventually wipe its hands clean of costs associated with the distribution of primary health and mental health services.

In order for an integrated mental health system to become a tangible reality, a dialogue between spiritual and allopathic psychological healers must first be initiated. If an integrated system were to function effectively with respect to the incorporation of spiritually founded practices among primary health clinics, allopathic practitioners would have to be open to endorsing unempirical, unquantifiable treatments by traditional healers. Physicians must weigh their priorities and ask themselves, "What ideological sacrifices am I willing to make in order to ensure the widest-spread distribution of mental health services?" Provided that they conclude that augmenting the accessibility of therapies undermines the value of expending time and money to tediously rationalize every means of treatment employed, physicians should be able to reconcile the concept of faith with reason to promote the prospect of mental wellness for all in Madagascar.

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